



CATAG

Council of Australian
Therapeutic Advisory Groups

Medicines Access Program Prescriber Acknowledgement Form

I, _____ (print name) hereby accept responsibility for
prescribing the medicine _____ (medicine name)
under the specified Medicines Access Program.

Program name: _____

Sponsor/Company name: _____

Start date: _____ Stop date: _____

I understand that (please tick the following boxes):

- The medicine may not be subsidised by the Pharmaceutical Benefits Scheme (PBS) for my patients at the conclusion of the Medicines Access Program.
- The hospital is not expected to subsidise the cost of the medicine at the end of Medicines Access Program unless approved for use on the hospital formulary or the hospital's Drugs and Therapeutics Committee has approved non-formulary use in an individual patient.
- In the situation where the medicine is not subsidised by the end of the program, the medicine may need to be switched over to a suitable subsidised alternative. I will ensure that each patient understands this and discuss alternative treatments with them.
- Where the medicine does not have PBS listing at the conclusion of the Medicines Access Program, I will ensure that I obtain the required approval to continue prescribing the medicine for my patients. Failing that, I will switch the patient to a suitable subsidised alternative. I will organise the request for approval or the changeover to a suitable alternative in a timely manner.

Patient considerations (please tick boxes):

- I must provide information about the medicine and the program to each patient.
- I am required to obtain patient consent prior to using this medicine under the Medicines Access Program.
- I must make patients aware that usual hospital charges will apply to medicines dispensed under the Medicines Access Program.
- I must ask patients if they are prepared and able (have the means) to pay for the above medicine if they wish to continue therapy at the conclusion of the program.
- I must make patients aware of any actual, potential or perceived conflicts of interest I have in relation to this Medicines Access Program.

Declaration of conflict of interest:

- I certify that I am not aware of any conflict of interest which may arise in respect of this Medicines Access Program

OR

- I may have a conflict of interest for the following reason/s: _____

Prescriber's Signature

Name

Date

If signing on behalf of a consultant, please write the consultant's name
CATAG acknowledges the work of NSW and
Western Australian Therapeutics Advisory Groups in the development of this
document. January 2018